Texas Department of Insurance
Division of Workers' Comp
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

VISTA SURGICAL CENTER WEST
4301 VISTA ROAD
PASADENA TX 77504-2117

Respondent Name

LIBERTY MUTUAL FIRE INSURANCE

Carrier's Austin Representative Box

Box Number 01

MFDR Tracking Number

M4-05-8130-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Vista charges the above-referenced services at a fair and reasonable rate. Specifically, these rates are based upon a comparison of charges to other Carriers and the amount of reimbursement received for these same or similar services. The amount of reimbursement deemed to be fair and reasonable by Vista is at a minimum of 70% of billed charges. This is supported by a managed care contract with 'Focus.' 'This managed care contract supports Vista's argument that the usual and customary charges are fair and reasonable and **at the very minimum**, 70% of the usual and customary charges is fair and reasonable…the managed care contract shows numerous Insurance Carrier's willingness to provide 70% reimbursement for outpatient medical services." "…amounts paid to healthcare providers by third party payers are relevant to determining fair and reasonable workers' compensation reimbursement. Further, TWCC stated specifically that managed care contracts are fulfill the requirements of Texas Labor Code Section 413.011 as they are 'relevant to what fair and reasonable reimbursement is,' they are relevant to achieving cost control,' they are relevant to ensuring access to quality care,' and they are 'highly reliable.' See 22 TexReg 6272. Finally, managed care contracts were determined by the TWCC to be the best indication of a market price voluntarily negotiated for medical services."

Amount in Dispute: $4,636.09

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The bill and documentation attached to the medical dispute has been re-reviewed and our position remains the same. The bill was processed as follows: **The entire bill was denied x591, per independent medical exam, no further treatment is necessary**."

Response Submitted by: Liberty Mutual Insurance, 2875 Browns Bridge Road, Gainesville, GA 30504

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 10, 2004	Outpatient Surgery	$4,636.09	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.308 sets out the procedure for resolving medical necessity disputes.
3. 28 Texas Administrative Code §134.600(h)(2) effective March 14, 2004, requires preauthorization for outpatient surgical or ambulatory surgical services.
4. 28 Texas Administrative Code §134.1, effective May 16, 2002, 27 *Texas Register* 4047, requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
5. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
6. This request for medical fee dispute resolution was received by the Division on May 11, 2005. Pursuant to 28 Texas Administrative Code §133.307(g)(3), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on May 23, 2005 to send additional documentation relevant to the fee dispute as set forth in the rule.
7. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of Benefits dated August 12, 2004

   - U-Unnecessary medical treatment (without peer review).
   - X591-Per independent medical exam, no further treatment is necessary.
   - F-Reduction according to fee guideline.
   - Z652-Recommendationof payment has been based on a procedure code which best describes services rendered.

Findings

1. The respondent denied reimbursement for the disputed services based upon "U-Unnecessary treatment (without peer review)."

   28 Texas Administrative Code §134.600(h)(2) effective March 14, 2004, requires preauthorization for "outpatient surgical or ambulatory surgical services, as defined in subsection (a) of this section." The Division finds that the requestor did not submit documentation to support the disputed service(s) had been preauthorized and medically necessary.

   28 Texas Administrative Code §133.308(a)(1) states in part "This rule applies to the independent review of prospective or retrospective medical necessity disputes (a review of health care requiring preauthorization or concurrent review, or retrospective review of health care provided) for which the dispute resolution request was filed on or after January 1, 2003." The requestor did not submit documentation to support the medical necessity issues were resolved prior to seeking medical fee dispute resolution in accordance with28 Texas Administrative Code §133.308.

   28 Texas Administrative Code §133.307(g)(2) states "If the request contains unresolved medical necessity issues, the commission shall notify the parties of the review requirements pursuant to §133.308." Because the requestor did not submit documentation to support the services were preauthorized, nor that the medical necessity had been resolved, the Division does not have jurisdiction to review this fee dispute per 28 Texas Administrative Code §133.307.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	01/25/2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.